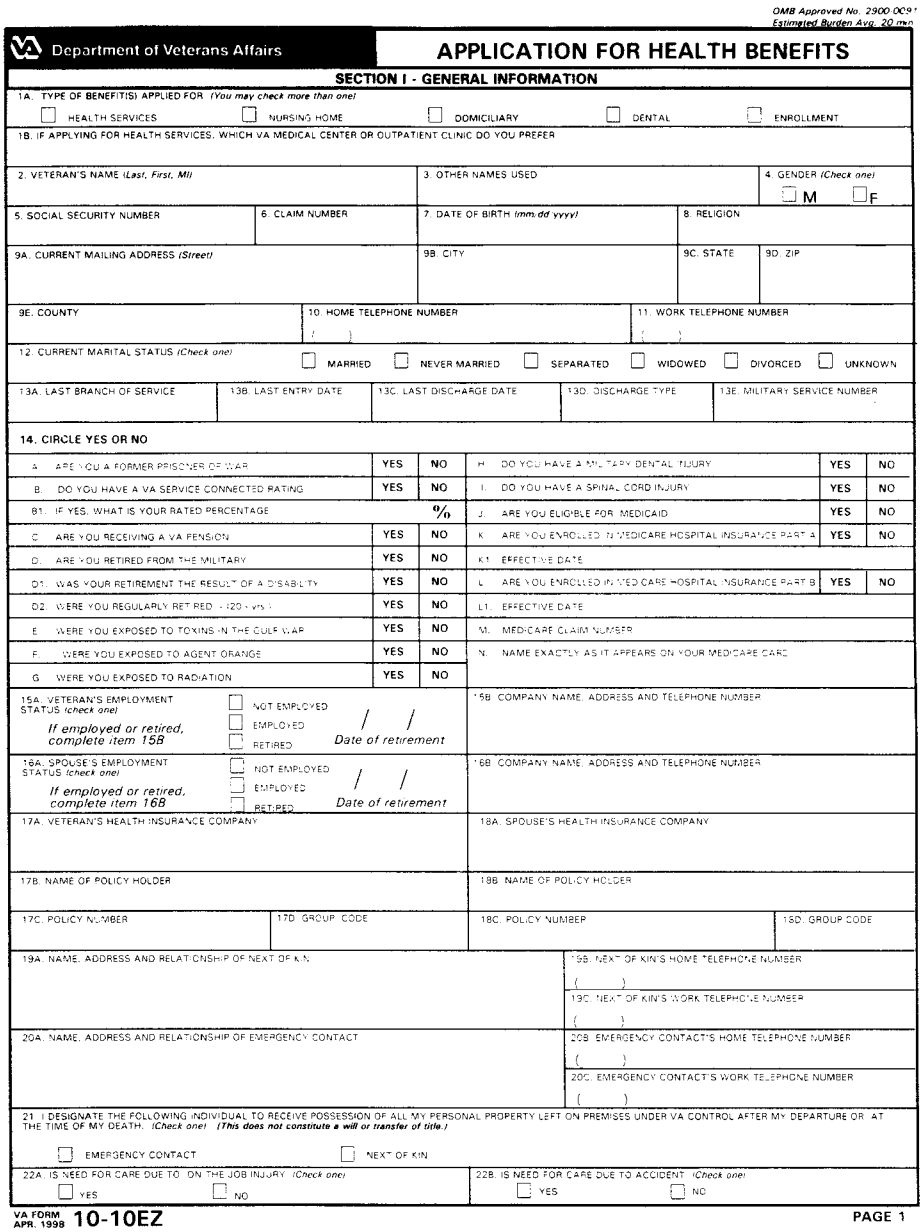
## § 58.12 VA Form 10–10EZ—Application for Health Benefits



OMB Approved No. 2900-0091
Estimated Burden Avg. 20 min

Department of Veterans Affairs

**APPLICATION FOR HEALTH BENEFITS**

**SECTION I - GENERAL INFORMATION**

1A. TYPE OF BENEFIT(S) APPLIED FOR *(You may check more than one)*
☐ HEALTH SERVICES ☐ NURSING HOME ☐ DOMICILIARY ☐ DENTAL ☐ ENROLLMENT

1B. IF APPLYING FOR HEALTH SERVICES, WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER

2. VETERAN'S NAME *(Last, First, MI)* | 3. OTHER NAMES USED | 4. GENDER *(Check one)* ☐ M ☐ F

5. SOCIAL SECURITY NUMBER | 6. CLAIM NUMBER | 7. DATE OF BIRTH *(mm.dd.yyyy)* | 8. RELIGION

9A. CURRENT MAILING ADDRESS *(Street)* | 9B. CITY | 9C. STATE | 9D. ZIP

9E. COUNTY | 10. HOME TELEPHONE NUMBER ( ) | 11. WORK TELEPHONE NUMBER ( )

12. CURRENT MARITAL STATUS *(Check one)* ☐ MARRIED ☐ NEVER MARRIED ☐ SEPARATED ☐ WIDOWED ☐ DIVORCED ☐ UNKNOWN

13A. LAST BRANCH OF SERVICE | 13B. LAST ENTRY DATE | 13C. LAST DISCHARGE DATE | 13D. DISCHARGE TYPE | 13E. MILITARY SERVICE NUMBER

**14. CIRCLE YES OR NO**

| | | | | | |
|---|---|---|---|---|---|
| A. ARE YOU A FORMER PRISONER OF WAR | YES | NO | H. DO YOU HAVE A MILITARY DENTAL INJURY | YES | NO |
| B. DO YOU HAVE A VA SERVICE CONNECTED RATING | YES | NO | I. DO YOU HAVE A SPINAL CORD INJURY | YES | NO |
| B1. IF YES, WHAT IS YOUR RATED PERCENTAGE | | % | J. ARE YOU ELIGIBLE FOR MEDICAID | YES | NO |
| C. ARE YOU RECEIVING A VA PENSION | YES | NO | K. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A | YES | NO |
| D. ARE YOU RETIRED FROM THE MILITARY | YES | NO | K1. EFFECTIVE DATE | | |
| D1. WAS YOUR RETIREMENT THE RESULT OF A DISABILITY | YES | NO | L. ARE YOU ENROLLED IN MED CARE HOSPITAL INSURANCE PART B | YES | NO |
| D2. WERE YOU REGULARLY RETIRED (20+ yrs) | YES | NO | L1. EFFECTIVE DATE | | |
| E. WERE YOU EXPOSED TO TOXINS IN THE GULF WAR | YES | NO | M. MEDICARE CLAIM NUMBER | | |
| F. WERE YOU EXPOSED TO AGENT ORANGE | YES | NO | N. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD | | |
| G. WERE YOU EXPOSED TO RADIATION | YES | NO | | | |

15A. VETERAN'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED
*If employed or retired, complete item 15B* / / *Date of retirement*
15B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

16A. SPOUSE'S EMPLOYMENT STATUS *(check one)* ☐ NOT EMPLOYED ☐ EMPLOYED ☐ RETIRED
*If employed or retired, complete item 16B* / / *Date of retirement*
16B. COMPANY NAME, ADDRESS AND TELEPHONE NUMBER

17A. VETERAN'S HEALTH INSURANCE COMPANY | 18A. SPOUSE'S HEALTH INSURANCE COMPANY

17B. NAME OF POLICY HOLDER | 18B. NAME OF POLICY HOLDER

17C. POLICY NUMBER | 17D. GROUP CODE | 18C. POLICY NUMBER | 18D. GROUP CODE

19A. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN | 19B. NEXT OF KIN'S HOME TELEPHONE NUMBER ( ) | 19C. NEXT OF KIN'S WORK TELEPHONE NUMBER ( )

20A. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT | 20B. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER ( ) | 20C. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER ( )

21. I DESIGNATE THE FOLLOWING INDIVIDUAL TO RECEIVE POSSESSION OF ALL MY PERSONAL PROPERTY LEFT ON PREMISES UNDER VA CONTROL AFTER MY DEPARTURE OR AT THE TIME OF MY DEATH. *(Check one)* ***(This does not constitute a will or transfer of title.)***
☐ EMERGENCY CONTACT ☐ NEXT OF KIN

22A. IS NEED FOR CARE DUE TO ON THE JOB INJURY *(Check one)* ☐ YES ☐ NO | 22B. IS NEED FOR CARE DUE TO ACCIDENT *(Check one)* ☐ YES ☐ NO

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| APPLICATION FOR HEALTH BENEFITS, Continued | VETERAN'S NAME | SOCIAL SECURITY NUMBER |
|---|---|---|

**SECTION II - FINANCIAL ASSESSMENT**

**IIA - DEPENDENT INFORMATION** ***(Use a separate sheet for additional dependents)***

| 1. SPOUSE'S NAME (Last, First, MI) | 2. CHILD'S NAME (Last, First, MI) | |
|---|---|---|
| 3. SPOUSE'S SOCIAL SECURITY NUMBER | 4. SPOUSE'S DATE OF BIRTH (mm/dd/yyyy) | 5. CHILD'S DATE OF BIRTH (mm/dd/yyyy) |
| 6. SPOUSE'S ADDRESS (Street, City, State, ZIP) | 7. CHILD'S SOCIAL SECURITY NUMBER | |
| 8. SPOUSE'S TELEPHONE NUMBER | 9. CHILD'S RELATIONSHIP TO YOU (Circle one) Son Daughter Stepson Stepdaughter | |
| 10. DATE OF MARRIAGE (mm/dd/yyyy) | 11. DATE CHILD BECAME YOUR DEPENDENT | |
| 12. IF YOUR SPOUSE OR DEPENDENT CHILD DID NOT LIVE WITH YOU LAST YEAR, ENTER THE AMOUNT YOU CONTRIBUTED TO THEIR SUPPORT SPOUSE $ CHILD $ | 13. EXPENSES PAID BY YOUR DEPENDENT CHILD FOR COLLEGE, VOCATIONAL REHABILITATION OR TRAINING (tuition, books, materials, etc.) $ | |
| 14. WAS CHILD PERMANENTLY AND TOTALLY DISABLED BEFORE THE AGE OF 18? ☐ YES ☐ NO | 15. IF CHILD IS BETWEEN 18 AND 23 YEARS OF AGE, DID CHILD ATTEND SCHOOL LAST CALENDAR YEAR? ☐ YES ☐ NO | |

**IIB - FINANCIAL DISCLOSURE**

You are not required to provide the financial information in this Section. However, current law may require VA to consider your household financial situation to determine your eligibility for enrollment and/or cost-free care of your nonservice-connected (NSC) conditions. If you are 0% SC noncompensable or NSC (and are not an Ex-POW, WWI veteran or VA pensioner) and your annual household income (or combined income and net worth) exceeds the established threshold, you must agree to pay VA co-payments for care of your NSC conditions to be eligible for enrollment. See Section III - Consent and Signature.

☐ **YES,** I WILL PROVIDE SPECIFIC INCOME AND/OR ASSET INFORMATION TO HAVE ELIGIBILITY FOR CARE DETERMINED. *Complete all sections below that apply to you with last calendar year's information. Sign and date the application.*

☐ **NO,** I DO NOT WISH TO PROVIDE MY DETAILED FINANCIAL INFORMATION. *I understand I will be assigned the appropriate enrollment priority based on nondisclosure of my financial information. By checking NO and signing below, I am agreeing to pay the applicable VA co-payment. Sign and date the application.*

**IIC - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN**

| | VETERAN | SPOUSE | CHILDREN |
|---|---|---|---|
| 1. WHAT WAS YOUR GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.), AS WELL AS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS | $ | $ | $ |
| 2. LIST OTHER INCOME AMOUNTS (Social Security, compensation, pension, interest, dividends) Exclude welfare. | $ | $ | $ |
| 3. WAS INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS (If yes, refer to page 2, Section IIC of the instructions.) ☐ YES ☐ NO | | | |

**IID - DEDUCTIBLE EXPENSES**

| | |
|---|---|
| 1. NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (payments for doctors, dentists, drugs, Medicare, health insurance, hospital and nursing home) | $ |
| 2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also enter spouse or child's information in Section IIA) | $ |
| 3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (tuition, books, fees, materials, etc.) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES. | $ |

**IIE - NET WORTH**

| | VETERAN | SPOUSE |
|---|---|---|
| 1. CASH, AMOUNT IN BANK ACCOUNTS (Checking and savings accounts, certificates of deposit, individual retirement accounts, etc.) | $ | $ |
| 2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. Do not count your primary home. Include value of farm, ranch, or business assets. | $ | $ |
| 3. STOCKS AND BONDS AND VALUE OF OTHER PROPERTY OR ASSETS (art, rare coins, etc.) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. Exclude household effects and family vehicles. | $ | $ |

**SECTION III - CONSENT AND SIGNATURE**

**CO-PAYMENT NOTICE:** If you are a 0% service-connected noncompensable or a nonservice-connected veteran (and are not an Ex-POW, WWI veteran or VA pensioner) **and** your household income (or combined income and net worth) exceeds the established threshold, you may be eligible for enrollment only if you agree to pay VA co-payments for treatment of your NSC conditions. By signing this application you are agreeing to pay the applicable VA co-payment if required by law.

| I CERTIFY THE FOREGOING STATEMENT(S) ARE TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE AND ABILITY. | DATE (mm/dd/yyyy) |
|---|---|
| SIGN HERE (Signature of applicant or applicant's representative) | |

**THE LAW PROVIDES SEVERE PENALTIES FOR WILLFUL SUBMISSION OF FALSE INFORMATION.**